Leqvio® (Inclisiran)

Referring Provider Order Form – For Use with Participating Infusion Centers Rev. 09/2025

Please send completed referral form & all required documents to **referrals@healix.net** or fax to **281-295-4086**

HEALIX®

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height_____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ I25.10 Atherosclerotic cardiovascular disease (ASCVD)
☐ E78.011 Heterozygous Familial Hypercholesterolemia (HeFH)
☐ E78.00 Pure Hypercholesterolemia, unspecified
☐ E78.2 Mixed hyperlipidemia
☐ E78.49 Other hyperlipidemia
☐ E78.5 Hyperlipidemia, unspecified
☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Leqvio®(Inclisiran)	284 mg	**INITIAL:** ☐ First dose: Inject SubQ x 1 dose. ☐ Second dose at 3 months: Inject SubQ x 1 dose. **MAINTENANCE:** ☐ Inject SubQ every 6 months x 1 year.

Is patient currently receiving therapy above from another facility?

☐ NO ☐ YES

If yes, Facility Name:_____

Date of last treatment:_____ Date of next treatment:_____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Other:_____
☐ Diphenhydramine 25mg PO

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician
☐ No labs ordered at this time ☐ Other:_____
☐ LDL-C q _____ ☐ Lipid Panel q _____ ☐ LFTs q _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI:_____ Specialty:_____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

For all diagnoses:

☐ Yes ☐ No Does the patient have elevated LDL-C level?

- Recent LDL-C level: _____ mg/dL; Date lab drawn: _____ ***(Attach copy of labwork)***

☐ Yes ☐ No Is the patient currently on statin therapy?

Current statin therapy; Drug name: _____ Dosage: _____ Start date or Length of Therapy: _____

☐ Check box if patient is on Zetia® (ezetimibe) in addition to statin therapy.

If No, please specify: ☐ Patient is statin intolerant (list failed statin therapies and reasons below)

☐ Patient has a contraindication for statin therapy, specify: _____

☐ Other: _____

☐ Yes ☐ No Has the patient been compliant with lipid lowering drug therapy and lifestyle modifications?

For ASCVD only:

History of clinical atherosclerotic cardiovascular disease includes one of more of the following: ***(Select all that apply)***

☐ Acute coronary syndrome
☐ Coronary artery disease (CAD)
☐ History of myocardial infarction (MI)
☐ Stable or unstable angina
☐ Coronary or other arterial revascularization
☐ Stroke
☐ Transient ischemic attack (TIA)
☐ Peripheral arterial disease (PAD)
☐ Other: _____

For HeFH only:

HeFH confirmed by: ☐ Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein(LDLRAP1) gene ***(Attach copy of test results)***

☐ WHO/Dutch Lipid Clinic Network Score (DLCNS); Score: _____ ***(Attach copy of assessment)***

☐ Other: _____

LAB RESULTS (required)

☐ LDL cholesterol blood level

PRIOR FAILED THERAPIES (including statins and PCSK9 inhibitors)

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

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Medication: _____ Dates of Treatment: _____ Reason for D/C: _____